U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 17 August 2004

Case No. 2001-BLA-649

In the Matter of:
LASTEL LEWIS,
Claimant,

v.

ISLAND CREEK COAL COMPANY,
Employer,

and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

BEFORE: Administrative Law Judge
Thomas F. Phalen, Jr.

APPEARANCES:
Ronald Bruce, Esq.
On behalf of Claimant

Natalee Gilmore, Esq.
On behalf of Employer

DECISION AND ORDER ON REMAND – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On October 24, 2003, this claim was remanded to the Office of Administrative Law Judges by the Benefits Review Board for further consideration consistent with their decision and order.[2] Through a February 6, 2004 order, the undersigned permitted the parties to file briefs on remand.

ISSUES

The issue on remand in this case is:

1. Whether Claimant suffers from legal pneumoconiosis under § 718.202(a)(4).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Lastel Lewis ("Claimant") filed an initial claim for benefits under the Act on October 23, 1989. (DX 40). That claim was denied on April 2, 1990 by the Director, Office of Workers' Compensation Programs ("OWCP"). No further action was undertaken by Claimant.

Claimant filed the present claim for benefits under the Act on March 7, 2000. (DX 1). On June 19, 2000, the Director, Office of Workers' Compensation Programs ("OWCP") initially denied benefits, a decision Claimant appealed. (DX 18, 19). On March 28, 2000, the OWCP designated Island Creek Kentucky Mining ("Employer") as the putative responsible operator. (DX 22, 21). On February 7, 2001, the OWCP awarded benefits to Claimant. (DX 33). Employer appealed the decision on February 14, 2001, and requested a formal hearing before the Office of Administrative Law Judges. (DX 34, 35). On February 21, 2001, the Black Lung Disability Trust Fund began paying benefits in the interim. (DX 36). The case was forwarded to the Office of the Administrative Law Judges on April 9, 2001. (DX 41, 42). The undersigned presided over the hearing on December 4, 2001. I issued a decision and order denying benefits on October 30, 2002. After finding that Claimant established the existence of a totally disabling respiratory impairment, I determined that Claimant established a material change in conditions under § 725.309(d). Thus, I conducted a *de novo* review of the entire record. I then determined that Claimant failed to establish the presence of pneumoconiosis under any applicable subsection of § 718.202(a). Therefore, I found that Claimant failed to establish that he was totally disabled due to pneumoconiosis arising out of coal mine employment.

Claimant filed a notice of appeal with the Benefits Review Board ("Board") on November 18, 2002. On October 24, 2003, the Board issued a decision and order affirming in part, vacating in part, and remanded the claim to the undersigned for further consideration

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr" refers to the official transcript of this proceeding.

consistent with their decision and order. The Board affirmed, as unchallenged on appeal, the undersigned's findings that Claimant failed to establish the presence of pneumoconiosis under §718.202(a)(1-3) or the presence of clinical pneumoconiosis under § 718.202(a)(4). The Board also affirmed the undersigned's findings that the newly submitted evidence established the existence of a totally disabling respiratory impairment and thereby a material change in conditions as unchallenged on appeal. The Board ruled that the undersigned did not err in according less weight to the opinion of Dr. Traughber because his credentials were unknown. The Board ruled that the undersigned did not err in crediting Dr. Jarvis' opinion that Claimant's respiratory impairment was due to smoking. However, the Board determined that the undersigned did err in stating that Dr. Houser's credentials were unknown since the record does contain Dr. Houser's credentials. Therefore, the Board remanded the claim because of the impact of a correct view of Dr. Houser's credentials may have on the qualitative analysis of the evidence. On remand, the Board instructed the undersigned to consider the opinion of Dr. Simpao, an examining physician, since Dr. Simpao opined that Miner's respiratory impairment arose out of coal mine employment in addition to diagnosing the existence of coal workers' pneumoconiosis. Accordingly, the Board vacated the undersigned's finding that the evidence failed to establish the existence of legal pneumoconiosis under § 718.202(a)(4).

On remand, Claimant and Employer filed briefs. Claimant contends that the opinions of Drs. Traughber, Simpao, Houser, and Baker finding the presence of pneumoconiosis constitutes a preponderance of the evidence produced by examining physicians and should be given greater weight than the opinions of non-examining physicians. Claimant argued that the opinions of Drs. Jarboe, Castle, Repsher, and Morgan, who found that Claimant did not suffer from pneumoconiosis, should be given less weight because they did not examine Claimant. To the contrary, Employer summarizes that Drs. Lombard, Jarvis, Castle, Jarboe, Repsher, and Morgan all determined that Claimant does not suffer from legal pneumoconiosis. Employer added that Drs. Lombard, Jarvis, Castle, Jarboe, and Repsher are board-certified pulmonologists, with Dr. Morgan holding the British equivalency to a board-certification in internal medicine and the subspecialty of pulmonary disease. Therefore, Employer contends that the opinions of Drs. Lombard, Jarvis, Castle, Jarboe, Repsher, and Morgan should be accorded controlling weight based on the credentials and the force of their reasoned and documented opinions. Employer notes that Drs. Lombard and Jarvis examined Claimant. Employer argues that Drs. Simpao and Younes offered no explanation in support of the causation opinions and that Dr. Traughber did no apportion the contribution of coal dust and cigarette smoking to Claimant's respiratory impairment. After acknowledging that Drs. Houser and Baker examined Claimant and are both board-certified pulmonologists, Employer argued that their opinions are not entitled to controlling weight because their opinions are based on a one time examination in comparison to the other physicians who considered the other medical evidence of record.

MEDICAL EVIDENCE

I incorporate by reference, as if fully rewritten herein, the chest x-rays, pulmonary function tests, arterial blood gas studies, narrative medical opinions, and deposition testimony contained in the undersigned's October 30, 2002 decision and order denying benefits to the extent that it is not inconsistent with the evidence summarized herein.

DISCUSSION AND APPLICABLE LAW

Mr. Lester's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
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> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis. The Board has affirmed the undersigned's previous finding that Claimant has failed to establish the presence of pneumoconiosis under § 718.202(a)(1-3) or the presence of clinical pneumoconiosis under § 718.202(a)(4). Remaining for determination is whether Claimant has established the presence of legal pneumoconiosis under §718.202(a)(4).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

In the October 30, 2002 decision and order denying benefits, I considered the opinions of Drs. Traughber, Simpao, Lombard, Younes, Morgan, Houser, Castle, Jarboe, Repsher, Baker, and Jarvis. I found that nine physicians opined that Claimant suffered from a restrictive or obstructive pulmonary impairment. The nine physicians all agreed that Claimant's cigarette smoking history was a cause of Claimant's COPD. Therefore, I found that Claimant's cigarette smoking history was a significant contributing factor in causing Claimants' COPD. On the issue of whether Claimant's coal dust exposure history was a significant factor contributing to his pulmonary impairment, I determined that the two board-certified pulmonologists who ruled-out coal dust exposure as a contributing factor to Claimant's pulmonary impairment outweighed the three other physicians (two were board-certified pulmonologists and the credentials of the other physician was not contained in the record) who only identified cigarette smoking and asthma as contributing causes outweighed the four physicians (two were board-certified physicians but one of the opinions was entitled only to little weight, and two were of unknown credentials) who opined that Claimant's coal mine employment was a significant contributing factor. The Board found that the undersigned erred by noting that Dr. Houser's credentials were not contained in the record. It also instructed the undersigned to weigh the opinion of Dr. Simpao in the analysis of the presence or absence of legal pneumoconiosis under § 718.202(a)(4) because Dr. Simpao found that Claimant's pulmonary impairment arose out of coal mine employment.

It is of initial importance to render a finding regarding the length of Claimant's smoking history. At the hearing, Claimant testified that he smoked cigarettes in the amount of one-half to one pack per day for 45 years. He provided a similar response in his answers to Employer's interrogatories. Aside from Dr. Baker's notation that Claimant smoked cigarettes for only 12-13 years, the remaining examining physicians recorded smoking histories consistent with Claimant's interrogatory answer and testimony. Therefore, I find that Claimant smoked cigarettes in the amount of one-half to one pack per day for 45 years. This history amounts to a 22 ½ - 45 pack-year smoking history.

Dr. Traughber, whose credentials are not contained in the record, opined in 1989 that Claimant suffered from a pulmonary impairment caused by cigarette smoking and dust in the coal mines. I previously found that Dr. Traughber's opinion was reasoned and documented. However, after further consideration of Dr. Traughber's opinion, I find that it does not contain a reasoned and documented diagnosis of legal pneumoconiosis. His opinion can no longer be granted probative weight. The Act favors accuracy over finality. Thus, it is necessary to reverse my prior finding that Dr. Traughber's opinion is entitled to probative weight. Dr. Traughber completed a Medical History and Examination for Coal Workers' Pneumoconiosis form. Under the heading of cardiopulmonary diagnosis, Dr. Traughber listed coal workers' pneumoconiosis x-ray category 1/0 and nicotine addiction. Under the heading of impairment, Dr. Traughber stated, "I think that the patient has a moderate impairment though I cannot document it with his current test. His exercise gases would indicate that he has fairly good functioning at this level. However, with sustained exercise I think he would probably have difficulty." In response to the question on the form regarding the extent that his cardiopulmonary diagnoses contributed to the impairment, Dr. Traughber stated that he cannot apportion the amount due to his cigarette smoking and the amount due to dust in the coal mines. A careful review of Dr. Traughber's opinion reveals that he did not actually diagnose legal pneumoconiosis. Dr. Traughber's cardiopulmonary diagnosis of coal workers' pneumoconiosis x-ray category 1/0 appears to be a

diagnosis of clinical pneumoconiosis based on his chest x-ray interpretation. His only other cardiopulmonary diagnosis was a nicotine addiction. He summarized the findings of the pulmonary function test as revealing a severe obstructive impairment, however, he added that he could not assess Claimant's true capabilities because of Claimant's poor cooperation and effort; Dr. Traughber found the pulmonary function test to be invalid. From the arterial blood gas study, Dr. Traughber detected hypoxemia at rest, but he never connected it to coal dust exposure. Thus, Dr. Traughber did not diagnose the presence of legal pneumoconiosis. The fact that Dr. Traughber's opinion was provided in 1989 should have been considered in the October 30, 2002 decision and order, as it was ten years older than the other opinions in the record. Since Dr. Traughber's opinion was ten years older than the other opinions of record and did not contain a diagnosis of legal pneumoconiosis, it is not probative of the sole issue on remand.

Dr. Simpao, whose credentials are not contained in the record, examined Claimant in May 2000. Dr. Simpao noted that Claimant began smoking one-half pack of cigarettes in 1953 and stopped smoking in 1994. He considered a coal mine employment history of 42 years. Dr. Simpao interpreted the chest x-ray as positive for pneumoconiosis, found the pulmonary function test to reveal a moderate degree of reversible and a severe degree of obstructive airway disease, and determined that the arterial blood gas study showed ventilatory perfusion mismatch with borderline hypoxia. Dr. Simpao's sole cardiopulmonary diagnosis was "CWP 1/1." Dr. Simpao, in response to the question asking the etiology of the cardiopulmonary diagnosis, stated that Claimant's "multi years of coal dust exposure is medically significant in his pulmonary impairment." On a separate form completed the same day in May 2000, Dr. Simpao answered that Claimant suffered from an occupational lung disease arising out of coal mine employment based on "findings on chest x-ray, arterial blood gas, EKG, pulmonary function test along with physical findings and symptomatology." He also marked that Claimant suffered from a moderate pulmonary impairment, listing pneumoconiosis as its etiology.

Dr. Simpao's opinions present a constant dilemma posed by the specific phrases that he and other physicians employ and the manner in which they complete the Medical History and Examination for Coal Workers' Pneumoconiosis and accompanying Treating Physician form. Dr. Simpao's sole cardiopulmonary diagnosis was CWP 1/1, which appears to be his chest x-ray interpretation. Despite the forms request that he set forth the rationale that he employed to reach this diagnosis, Dr. Simpao merely entered "CWP 1/1." His response to the question asking him to identify the etiology of his cardiopulmonary diagnosis of CWP 1/1, which was the utterance of Claimant's coal dust exposure being medically significant in causing Claimant's pulmonary impairment, seems to be more of an opinion that Claimant's pulmonary impairment arose out of coal dust exposure rather than an opinion that Claimant's CWP 1/1 arose out of coal mine employment. Dr. Simpao then answers on the accompanying Treating Physician form that Claimant suffers from an occupational lung disease arising out of coal mine employment. To further obfuscate matters, his rationale comes in the form of a kitchen sink answer stating that Claimant's history and symptoms, the results of his physical examination, and the results of his objective testing support his diagnosis that Claimant suffers from an occupational lung disease arising out of coal mine employment. However, he does not indicate how these categories specifically support his opinion. For example, what symptomatology supports his opinion that Claimant suffers from an occupational lung disease arising out of coal mine employment? Is it Claimant's sputum production, or his shortness of breath when moving the yard, or is it his

cyanotic nails and lips, or is it his dull chest pain? Or, is it all of Claimant's symptoms? How does Claimant's arterial blood gas study support his diagnosis? He found the EKG to be abnormal and suggestive of ischemia. How does that support his diagnosis of an occupational lung disease arising out of coal mine employment?

In summary, Dr. Simpao's cardiopulmonary diagnosis of CWP 1/1 appears to merely be a diagnosis of clinical pneumoconiosis by chest x-ray. His answer to the etiology of Claimant's CWP 1/1 could amount to a diagnosis of legal pneumoconiosis. Dr. Simpao's "Yes" answer on the accompanying Treating Physician form, could amount to a diagnosis of legal pneumoconiosis, clinical pneumoconiosis, or both. Dr. Simpao's kitchen sink rationale in support of his "Yes" answer does not distinguish his diagnosis, nor does it amount to a reasoned and documented diagnosis. By only identifying the general category of the evidence he relied upon, Dr. Simpao's opinion prevents a reviewing authority from determining whether he relied upon adequate data to support his conclusion. Dr. Simpao's diagnoses could be construed as diagnoses of clinical pneumoconiosis and legal pneumoconiosis. However, they could also be construed as an opinion addressing the issue of whether or not Claimant's totally disabling respiratory impairment was due, at least in part, to his pneumoconiosis. Regardless of whether Dr. Simpao's diagnoses can be evaluated under § 718.202(a)(4) or § 718.204(c) or both, the only logical conclusion is that he has an opinion that claimant suffers from pneumoconiosis, but his opinions are not sufficiently reasoned and documented. It is painfully obvious that Dr. Simpao concluded that Claimant suffered from some form of pneumoconiosis arising out of coal mine employment and some measure of a pulmonary impairment arising out of coal mine employment. There is ample objective evidence to support Dr. Simpao's conclusion. However, since his report fails to adequately marshal the evidence in such a manner so as to allow a reviewing authority to determine the reliability of his conclusions, I cannot determine if Dr. Simpao diagnosed the existence of legal pneumoconiosis or not. Therefore, I find that his report does not contain a reasoned medical opinion addressing the presence or absence of pneumoconiosis that may be evaluated under § 718.202(a)(4). Dr. Simpao's opinion is simply not clear enough to be probative of whether or not Claimant suffers from legal pneumoconiosis.

Dr. Lombard examined Claimant in December 2000 and rendered a narrative medical opinion. He conducted a chest x-ray and obtained a B-reader interpretation, pulmonary function test, arterial blood gas study, measured Claimant's diffusing capacity, and a pulmonary stress test. Dr. Lombard considered a 25 pack-year cigarette smoking history and a history of coal mine employment beginning in 1946 and ending in 1997. Due to the reversibility of the moderate degree of Claimant's COPD, he determined that a substantial portion of Claimant's COPD was due to asthma. Dr. Lombard opined that Claimant's cigarette smoking was a contributing factor, but he excluded coal dust exposure as a contributing factor. In light of the degree of reversibility, Dr. Simpao opined that Claimant may have developed the problem *de novo*. Dr. Lombard considered an accurate account of Claimant's smoking and coal mine employment history. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Lombard's opinion is entitled to probative weight.

I continue to find that Dr. Younes completion of a questionnaire propounded to him by the OWCP on January 23, 2001 does not amount to a reasoned medical opinion. He did not set

forth clinical observations and findings, nor did he cite to sufficient objective data to support his conclusion. Therefore, acknowledging that Dr. Younes is a board-certified pulmonologist, I accord his opinion a lesser degree of probative weight.

I previously accorded Dr. Morgan's April 2001 opinion probative weight after finding that it was a reasoned medical opinion. He opined that there was no objective evidence of coal workers' pneumoconiosis. While he detected a moderate airways obstruction and a restrictive impairment, he attributed the obstructive component to Claimant's smoking history and the restrictive component to the opening of Claimant's chest in connection with his coronary bypass surgery. Dr. Morgan noted that the progressive worsening of Claimant's obstruction after the age of 60 is a common finding in a cigarette smoker who develops emphysema. Dr. Morgan considered an accurate account of Claimant's smoking and coal mine employment history. Specifically, he reviewed and summarized records showing that Claimant engaged in coal mine employment for 41 years, even though he found that Claimant "has not had a prolonged exposure to coal mine dust," after calculating that only nine years underground with only a relatively short time being spent at the coal face.[3] Dr. Morgan did set forth clinical observations and findings, and his reasoning is supported by adequate data. Therefore, I conclude that his opinion is moderately well reasoned and documented, and I find that Dr. Morgan's opinion is entitled to some probative weight enhanced by his credentials as the British equivalent of a board-certified pulmonologist.

Dr. Houser issued a reasoned and documented opinion after he examined Claimant on May 11, 2001. He opined that Claimant suffers from severe COPD that was significantly contributed to by his coal and rock dust exposure as well as by cigarette smoking. Dr. Houser concluded that cigarette smoking and exposure to coal mine dust are associated with abnormal pulmonary function and in some cases marked reduction in function similar to that observed in Claimant's case. Dr. Houser considered an accurate account of Claimant's smoking and coal mine employment histories (45 pack-year smoking history and 41 years of coal mine employment). He referenced scientific medical literature identifying occupational dust exposure as a cause of COPD. In continue to accord probative weight to Dr. Houser's reasoned and documented opinion enhanced by his credentials as a board-certified pulmonologist.

Dr. Castle issued a consultative opinion in May 2001 after reviewing and summarizing Claimant's medical records. He concluded that Claimant does not suffer from coal workers' pneumoconiosis. Dr. Castle did find the presence of a moderate degree of airway obstruction, but he attributed it solely to Claimant's cigarette smoking and asthma due to the very significant degree of reversibility after the administration of bronchodilators. Dr. Castle also noted that the findings from the physicians who conducted physical examinations of Claimant detected reduced breath sounds consistent with tobacco smoke induced airway obstruction or bronchial asthma. I continue to find that Dr. Castle's opinion is reasoned and documented. Dr. Castle considered an accurate account of Claimant's smoking and coal mine employment history. He set forth clinical observations and findings, and his reasoning is supported by adequate data. I find that Dr.

[3] I find that even 9 years of underground coal mine employment of the 41 years which has been credited to claimant, constitutes significant exposure to coal dust as a matter of law and that his conclusion that claimant "has not had a prolonged exposure to coal mine dust" dilutes the weight to be given to his final conclusions.

Castle's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Jarboe rendered a consultative report in June 2001. After opining that the chest x-ray evidence was negative for the presence of pneumoconiosis, he opined that the evidence as a whole was negative for pneumoconiosis. He elaborated on this opinion, noting that the spirometric pattern could be seen in a dust induced lung disease. However, he concluded that the lack of a restrictive defect (evidenced by the lack of reduction in FVC and preservation of total lung capacity) and the significant reversible component to the airflow obstruction argued against a relationship between Claimant's lung disease and his dust exposure. He suggested that the reversible component of Claimant's airflow obstruction identified another etiology, such as cigarette smoking or bronchial asthma. I continue to find that Dr. Jarboe's opinion is reasoned and documented. He considered an accurate account of Claimant's smoking and coal mine employment history. Dr. Jarboe set forth clinical observations and findings, and his reasoning is supported by adequate data. Therefore, I find that Dr. Jarboe's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

I previously found that Dr. Repsher's July 2001 consultative opinion was reasoned and documented, but I accorded his opinion a lesser degree of probative weight. While Dr. Repsher opined that his review of the medical evidence led him to conclude that there was insufficient evidence to support a diagnosis of coal workers' pneumoconiosis, he declined to draw a conclusion as to whether Claimant suffered from a respiratory or pulmonary impairment because he alleged that Claimant performed his pulmonary function testing with such poor effort that they were not medically interpretable to detect the presence or absence of any pulmonary disease. Dr. Repsher's opinion does not address the presence or absence of legal pneumoconiosis. Therefore, it is not probative of whether or not Claimant suffers from legal pneumoconiosis, except to the extent that his opinion argues that the pulmonary function testing is not valid.

Dr. Baker examined Claimant and issued a narrative medical report on August 15, 2001. Dr. Baker considered a 12-13 pack-year smoking history and a 41-year history of coal mine employment. He noted that Claimant had no history of tuberculosis, asthma, pneumonia, or hemoptysis. He interpreted a chest x-ray as positive for pneumoconiosis. Dr. Baker diagnosed the presence of coal workers' pneumoconiosis based on the abnormal chest x-ray, Claimant's significant history of coal dust exposure, and the absence of other conditions to account for Claimant's x-ray changes. He interpreted a pre- and post-bronchodilator pulmonary function test as revealing a moderate obstructive ventilatory defect. Dr. Baker stated that the approximately 10% improvement in the FEV1 suggested some degree of bronchospasm present but no distinct reversibility. He thought "that any pulmonary impairment is caused at least in part, if not significantly so, by his coal dust exposure." Dr. Baker also diagnosed chronic bronchitis by history, but he did not opine that coal dust exposure was a contributing factor. Dr. Baker did render a diagnosis of legal pneumoconiosis: a moderate obstructive ventilatory defect that is caused at least in part, if not significantly so, by Claimant's coal dust exposure. However, he did not provide any rationale to support his conclusion that coal dust exposure was a significant contributing factor. Dr. Baker significantly underestimated the length of Claimant's smoking history. He set forth clinical observations and findings, but he failed to provide any rationale.

Thus, I cannot determine whether his opinion is supported by adequate data. Since he considered an inaccurate smoking history and failed to document his conclusion, I find that Dr. Baker's report does not contain a reasoned medical opinion addressing the presence or absence of legal pneumoconiosis. Accordingly, Dr. Baker's August 2001 report is not probative of whether or not Claimant suffers from legal pneumoconiosis.

Dr. Jarvis examined Claimant in October 2001. He considered a smoking history of one-half pack per day ending 12 years prior and a coal mine employment history of 41 years. From a chest x-ray, Dr. Jarvis detected emphysema. He interpreted a chest x-ray as revealing a severe obstructive impairment. Dr. Jarvis' impressions were severe COPD with bronchospasm status post tobacco abuse, ischemic heart disease status post coronary artery bypass graft, mild obesity, and coal dust exposure. He opined that Claimant appears to have advanced COPD almost certainly from his previous tobacco habit. Dr. Jarvis found no evidence of coal workers' pneumoconiosis, and he attributed all of Claimant's pulmonary disease to smoking, COPD, and wheezing. Dr. Jarvis supported this conclusion during his deposition testimony by noting that tobacco smoke is the main irritant that causes COPD. I continue to find that Dr. Jarvis' opinion was reasoned and documented. He set forth clinical observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Claimant's smoking and coal mine employment history. Therefore, I find that Dr. Jarvis' opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

There were eleven physicians who rendered narrative medical opinions. Of those eleven, I have determined that six are probative of the presence or absence of legal pneumoconiosis. Dr. Houser diagnosed the presence of legal pneumoconiosis, while Drs. Lombard, Morgan, Castle, Jarboe, and Jarvis found that Claimant did not suffer from legal pneumoconiosis. The evidence, primarily the pulmonary function testing, establishes that Claimant suffers from a moderate to sever degree of chronic obstructive pulmonary disease which improves after the administration of a bronchodilator. Claimant may also suffer from a mild restrictive pulmonary impairment. All six physicians who rendered reasoned medical opinions that addressed the presence or absence of legal pneumoconiosis agreed that Claimant's cigarette smoking history was a contributing factor to Claimant's obstructive pulmonary disease. Only Dr. Houser found Claimant's coal dust exposure to also be a significant contributing factor to his severe chronic obstructive pulmonary disease. The preponderance of the reasoned medical opinion evidence excludes Claimant's coal dust exposure as a significant contributing factor to Claimant's pulmonary impairments. Dr. Morgan attributed Claimant's restrictive impairment to the effect of undergoing a coronary artery bypass graft. Drs. Jarboe, Lombard, and Castle point out that the significant degree of reversibility after the administration of bronchodilators is significant evidence that Claimant's obstructive pulmonary impairment is caused by coal dust exposure or asthma. Dr. Houser did not address Claimant's response to bronchodilators, nor did he consider whether or not Claimant suffered from asthma. While Dr. Houser's opinion is entitled to enhanced probative weight because of his credentials and reliance upon scientific medical literature, his opinion is outweighed by the combined weight of the opinions of Drs. Lombard, Morgan, Castle, Jarboe, and Jarvis. Drs. Castle, Jarboe, and Jarvis are also board-certified pulmonologists, which garnered their opinion enhanced probative weight also. Since the preponderance of the reasoned medical evidence establishes that coal dust exposure was not a

significant contributing cause of Claimant's pulmonary impairments, I find that Claimant has failed to establish that he suffers from legal pneumoconiosis under §718l.202(a)(4).

I have determined that Claimant has failed to establish the presence of pneumoconiosis under any applicable subsection of § 718.202(a). Accordingly, I find that Claimant has failed to establish that he suffers from pneumoconiosis.

Entitlement

Claimant, Lastel Lewis, has failed to establish that he is totally disabled due to pneumoconiosis arising out of coal mine employment. Therefore, I find that Mr. Lewis is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Lastel Lewis for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**